Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FT WORTH

Respondent Name
FRANK WINSTON CRUM INSURANCE INC

MFDR Tracking Number
M4-15-1160-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
December 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. All of this documentation was sent in for reconsideration to the carrier several times. This is an approved case with all other claims being paid in full. Patient has authorization for work conditioning program with our office. All other work conditioning visits were paid in full. Office visits are recommended to be medically necessary. Carrier shall not withdraw a preauthorization or concurrent review approval once issued. Please see attached patient account statement showing all other claims being paid in a timely manner. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $304.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the medical fee dispute resolution request from Elite Healthcare Ft. Worth p concerning the above referenced claim for dates of service 9/11/13-9/12/13. The carrier asserts that as per Rule 133.307 (c)(1), the request for MFDR was not filed timely. In addition the carrier maintains its position that the original bill was not submitted timely and thus the bill was denied."

Response Submitted by: BROADSPIRE

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 11, 2013 to September 12, 2013	CPT Code 99213, 97545, 97546 and 99080	$304.19	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

- D10 – The time limit for filing has expired
- W1 – Workers' Compensation jurisdictional fee schedule adjustment
- 18 – Exact duplicate claim/service
- 224 – Duplicate charge

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is September 11, 2013 to September 12, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 15, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/13/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.